File

18 September 1967

NOTE TO: DC/BSD

I have reviewed the attached proposed amendments to the health benefits regulations and have no comments or recommendations other than to state that one particular change is welcomed by us, that being the change regarding coverage of employees under cooperative work-study programs. When this change becomes effective, the limit of 365 days of LWOP coverage will not apply to them. (See page 7 of the changes; page 2 of the explanations.) We have a couple of cases which were about to exhaust their 365 days. This change now lifts the ceiling for them.

STAT

Acting Chief, Insurance Branch

SENDER WILL CHECK CLASSIFICATION TOP AND BOTTOM

UNCLASSIFIED | CONFIDENTIAL | SECRET

OFFICIAL ROUTING SLIP

TO	NAME AND ADDRESS	DATE	INITIALS
1	AC/Insurance Branch 406, Magazine Bldg.	9/13/67	WOB
2	DC/BSD	9/25/67	
3	STAT		
4	Please see		
5	Bill's comments, (Papas dips)		
6	STAT		

	ACTION		DIRECT REPLY		
	APPROVAL		DISPATCH		RECOMMENDATION
	COMMENT		FILE		RETURN
	CONCURRENCE		INFORMATION		SIGNATURE

Remarks:

Will you please look this over giving it a strict review and let me have any comments or suggestions that you have as soon as possible.

Thanks! SEP 1967

STAT

FOLD HERE TO SENDER

FROM: NAME, ADDRESS AND PHONE NO.	DATE
STAT	
STAT DC/BSD 5E47, Hq.	12 SEP 1967

UNCLASSIFIED | CONFIDENTIAL | SECRET

FORM NO. 1-67 237 Use previous editions (40)

UNITED STATES CIVIL SERVICE COMMISSION

BUREAU OF RETIREMENT AND INSURANCE

WASHINGTON, D.C. 20415

IN REPLY PLEASE REFER TO

September 8, 1967

YOUR REFERENCE

STAT [redacted] President
Government Employees Health Assn., Inc.
Post Office Box 463
Washington, D. C. 20044

STAT Dear [redacted]

Attached are copies of proposed amendments to the health benefits regulations, with brief explanations. Most of the changes are editorial, to clarify present provisions, to eliminate obsolete material, or to reflect the codification of the health benefits act as 5 U.S.C., Chapter 89. Proposals which have substantive effect are identified in the explanations--of most significance is section 890.301(1-1) which would permit a person to change from high to low option at any time after he becomes eligible for Medicare.

These amendments were published in the Federal Register on September 2, 1967 as proposed rule making. You have thirty days from that date to submit any comments.

It is expected that the effective date of the amendments adopted after consideration of comments will be January 1, 1968, except the amendments to sections 890.301(1-1), 890.303(c), and 890.303(e) which would become effective upon promulgation. We will assume you have no objection to the earlier effective date for any of these three amendments if you do not specifically object.

Sincerely yours,

Andrew E. Ruddock

Andrew E. Ruddock
Director

Enclosures

UNITED STATES CIVIL SERVICE COMMISSION

[5 CFR PART 890]

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

NOTICE OF PROPOSED RULE MAKING

Notice is hereby given that under authority of section 8913 of title 5, United States Code, it is proposed to amend Part 890 of Title 5 of the Code of Federal Regulations as hereinafter set forth.

The amendments to sections 890.301(1-1), 890.303(c), and 890.303(e) are proposed to become effective upon publication in the Federal Register after expiration of this thirty-day notice of proposed rule making. The other amendments are proposed to become effective on January 1, 1968.

Interested persons may submit written comments, objections, or suggestions to the United States Civil Service Commission, Bureau of Retirement and Insurance, Washington, D. C. 20415, within thirty days of the date of publication of this notice of proposed rule making in the Federal Register.

Subparagraphs (1) and (8) of section 890.101(a) are proposed to be amended to read as follows:

§ 890.101 Definitions; time computations.

(a) In this part:

(1) Terms defined by section 8901 of title 5, United States Code, have the meanings there set forth.

* * *

(8) "Pay period" means the biweekly pay period established pursuant to section 5504 of title 5, United States Code, for the employees to whom that section applies, the regular pay period for employees not covered by that section; and the period for which a single installment of annuity is customarily paid for annuitants.

* * * * *

Subparagraphs (1), (4), and (6) of section 890.201(a) are proposed to be amended to read as follows:

§ 890.201 Minimum standards for health benefits plans.

(a) To be qualified to be approved by the Commission, a health benefits plan shall:

(1) Comply with Chapter 89 of title 5, United States Code, and this part, as amended from time to time.

* * *

(4) Provide for conversion to a contract for health benefits regularly offered by the carrier, or an appropriate affiliate, for group conversion purposes, which shall be guaranteed renewable, subject to such amendments as apply to all contracts of this class, except that it may be canceled for fraud, over-insurance, or nonpayment of periodic charges. A carrier shall permit conversion within the time allowed by the temporary extensions of coverage provided under § 890.401 for each employee, annuitant, and member of family entitled to convert. When an employing office gives an employee written notice of his privilege of conversion, the carrier shall permit conversion at any time before

(i) 15 days after the date of notice or (ii) 75 days after his enrollment is terminated, whichever is earlier. When the Commission requests an extension of time for conversion because of delayed determination of ineligibility for immediate annuity, the carrier shall permit conversion until the date specified by the Commission in its request for extension. On conversion, the contract becomes effective as of the day following the last day of the temporary extension, and the employee, annuitant, or member of the family, as the case may be, shall pay the entire cost thereof directly to the carrier. The non-group contract may not deny or delay any benefit covered by the contract for a person converting from a plan approved under this part except to the extent that benefits are continued under the health benefits plan from which he converts.

* * *

(6) Provide a standard rate structure which contains, for each option, one standard individual rate, and one standard family rate.

* * *

Paragraph (b) of section 890.201 is proposed to be amended to read as follows:

(b) To be qualified to be approved by the Commission, a health benefits plan shall not:

(1) Deny a covered person a benefit provided by the plan for a service performed on or after the effective date of coverage solely because of a preexisting physical or mental condition.

(2) Require a waiting period for any covered person for benefits which it provides.

(3) Have more than two options.

(4) Have an initiation, service, enrollment, or other fee or charge in addition to the rate charged for the plan, except that a comprehensive medical plan may impose an additional charge to be paid directly by the employee or annuitant for certain medical supplies and services, if the supplies and services on which additional charges are imposed are clearly set forth in advance and are applicable to all employees and annuitants. This subparagraph does not apply to charges for membership in employee organizations sponsoring or underwriting plans.

(5) Subparagraphs (1) and (2) of this paragraph do not preclude a plan offering benefits for dentistry or cosmetic surgery, or both, limited to conditions arising after the effective date of coverage.

(6) Subparagraphs (1) and (2) of this paragraph do not preclude a plan, with the approval of the Commission, from limiting benefits for services performed for a person who, on the effective date of enrollment or change of enrollment, is confined in a hospital or other institution so long as the person is continuously confined therein. In the previous sentence, the term, "continuously confined" means one or more periods of confinement without a break of 31 consecutive days between actual confinements except that a carrier, by agreement with the Commission, may provide that a shorter break terminates a continuous confinement. However, benefits for a person hospitalized on the effective date of enrollment may not be limited:

(i) If the enrollment or change is because of discontinuance of his former health benefits plan, in whole or in part, or

(ii) If the change of enrollment is pursuant to an order of the Bureau of Retirement and Insurance, or

(iii) If the services are provided for injuries suffered in an accident which occurred, or for an illness first diagnosed or treated, after the date an employee's or annuitant's employing office received a registration to change the covering enrollment from one plan or option to another.

The introductory paragraph of section 890.202 is proposed to be amended to read as follows:

§ 890.202 Minimum standards for health benefits carriers.

The carrier of an approved health benefits plan must meet the requirements of Chapter 89 of title 5, United States Code, and the following requirements:

* * * * *

Section 890.301 is proposed to be amended by revoking subparagraph (d)(2) and by introducing a new paragraph (l-1) between paragraphs (l) and (m) to read as follows:

§ 890.301 Opportunities to register to enroll and change enrollment.

* * * * *

(l-1) On becoming eligible for benefits under Title XVIII of the Social Security Act. An enrolled employee or annuitant may register, at any time after the employee or his spouse becomes eligible for

benefits under Title XVIII of the Social Security Act, to change his enrollment from high option to low option within the same plan.

* * * * *

Paragraphs (c) and (e) of section 890.303 are proposed to be amended to read as follows:

§ 890.303 Continuation of enrollment.

* * * * *

(c) On death. The enrollment of a deceased employee or annuitant who is enrolled for self and family is transferred automatically to his eligible survivor annuitants. The enrollment is considered to be that of the survivor annuitant from whose annuity all or the greatest portion of the withholding for health benefits is made. It covers members of the family of the deceased employee or annuitant. A spouse who remarries before attaining age 60 is not a member of the family of the deceased employee or annuitant.

* * * * *

(e) In nonpay status.

(1) Except as provided in section 406(b), (c) of Public Law 89-504 in regard to an employee on leave without pay to serve as a full-time officer or employee of an employee organization, the enrollment of an employee continues without cost to the employee while he is in nonpay status for up to 365 days. The 365 days' nonpay status may be continuous or broken by periods of less than 4 consecutive months in pay status. If an employee has at least 4 consecutive months in pay status

after a period of nonpay status he is entitled to begin the 365 days' continuation of enrollment anew. For the purposes of this paragraph, 4 consecutive months in pay status means any 4-month period during which the employee is in pay status for at least part of each pay period.

(2) However, in the case of an employee having a career-conditional or career appointment, or appointed under Schedule B of Part 213 of this chapter, who is employed under a cooperative work-study program of at least one year's duration which requires the employee to be in pay status during not less than one-third of the total time required for completion of the program, his enrollment continues without cost to him while he is in nonpay status so long as he is participating in the program.

* * * * *

Paragraph (c) of section 890.306 is proposed to be revoked.

* * * * *

Paragraph (c) of section 890.503 is proposed to be amended by amending subparagraphs (2) and (3) and adding subparagraph (4) to read as follows:

§ 890.503 Reserves.

* * * * *

(c)(1) * * *

(2) Except as provided by subparagraphs (3) and (4) of this paragraph, when, as of the end of a contract period, the total of all the reserves held by a carrier for the plan amounts to less than the total of the last five months' subscription charges paid from the fund to the

carrier for the plan, the carrier is entitled to payment from the contingency reserve of the lesser of: An amount equal to the difference between the total of the last five months' subscription charges paid from the fund to the carrier for the plan and the total of the reserves held by the carrier for the plan, or an amount equal to the excess, if any, of the contingency reserve over the preferred minimum balance. The Commission shall authorize this payment after receipt of the accounting report for the contract period. The carrier shall credit the amount so paid to the special reserve for the plan.

(3) If more than fifty percent of the enrollees in a carrier's experience-rated plan are stationed at posts of duty outside the United States, its possessions, and the Commonwealth of Puerto Rico, when the special reserve held by the carrier for the plan at the end of a contract period amounts to less than one/sixth of the last year's subscription charges paid from the fund to the carrier for the plan, the carrier is entitled to payment from the contingency reserve of the lesser of: An amount equal to the difference between one/sixth of the last year's subscription charges paid from the fund to the carrier for the plan and the total of the special reserve held by the carrier for the plan, or an amount equal to the excess, if any, of the contingency reserve over the preferred minimum balance. The Commission shall authorize this payment after receipt of the account report for the contract period. The carrier shall credit the amount so paid to the special reserve for the plan.

(4) The Commission may, by agreement with the carrier, approve community rating for a group-practice plan. If the contingency reserve of the carrier of a community rated plan exceeds the preferred minimum balance, the carrier may request the Commission to pay a portion of the reserve not greater than the excess of the contingency reserve over the preferred minimum balance. The carrier shall state the reason for the request. The Commission will decide whether to allow the request in whole or in part and will advise the plan of its decision.

UNITED STATES CIVIL SERVICE COMMISSION.

James C. Spry
Executive Assistant to the
Commissioners

EXPLANATIONS

890.101(a)(1) and (8). The Federal Employees Health Benefits Act is currently codified without substantive change as 5 U.S.C., Chapter 89. References to its statutory provisions have been changed in subparagraphs(1) and (8) to reflect the codification.

890.201(a). Subparagraph (1) -- to reflect codification of Health Benefits Act, (4) and (6) -- editorial changes for purposes of clarification.

890.201(b). Editorial changes for purposes of clarification.

890.202. To reflect codification of Health Benefits Act.

890.301. Paragraph (d)(2) -- to eliminate obsolete reference.

Paragraph (1-1) -- Because health benefits plans limit their benefits where a subscriber is also entitled to Medicare benefits, there is little, if any, advantage in being enrolled in the high, rather than the low, option. By allowing an enrollee to change his enrollment from a high option to a low option in the same plan when he or his spouse becomes eligible for Medicare, the enrollee is given an opportunity to reduce the cost of his health benefits protection in cases where he or his spouse is entitled to benefits under both programs.

890.303(c). Public Law 89-504, approved July 18, 1966, amended the retirement law to provide for continuation of survivor annuity to

certain widows and widowers upon their remarriage after age 60. The proposed amendment recognizes that these persons continue, in effect, to be members of the family of the deceased employee or annuitant and permits continuation of their health benefits enrollment when annuity continues.

890.303(e)(2). The introduction of the limitation on coverage while in non-pay status requiring return to pay status for four months before a new 365-day period of eligibility began was intended to prevent repeated coverage for up to 365 days in non-pay status with only minimal employment. At the time the change was introduced its effect on cooperative work-study student trainees was considered. On the basis of the information available as to the variety of patterns of work and study periods, it was believed that cooperative work-study student trainees would ordinarily be in a work status for four months or more often enough to prevent exhaustion of their non-pay coverage while in a study status. However, we have learned from agencies that there is a growing trend toward a pattern of three months' work and three months' study in cooperative work-study programs. Under these programs and our current regulations, entitlement to coverage in non-pay status will be exhausted in two years, while work-study programs ordinarily last three to five years. The proposed amendment is intended to protect these student-trainees, who usually are in work status fifty percent of the time, without affording extended coverage to seasonal employees working less than half the time.

890.306. To eliminate obsolete material.

890.503. Subparagraph (c)(2) -- this change reflects the changes in subparagraphs (c)(3) and (c)(4).

Subparagraph (c)(3) -- Subparagraph (c)(2) provides for payment from the contingency reserve to the carrier funds in excess of a preferred minimum balance when and to the extent that the total of all reserves held by the carrier is less than 5 months' subscription charges.

Ordinarily the average lag between the time a covered medical expense is incurred and the time a claim for the expense is paid is about 3 months and therefore a plan's usual accrued claims reserve is approximately 3 months' premium. We consider 2 months' premium to be a prudent objective of the special reserve -- hence, the standard of "5 months' premium" for determining when payments should be made from the plan's contingency reserve.

One plan presents a special problem because a majority of its enrollees are overseas and therefore its claims lag is substantially greater than that of other plans. This plan has had to set aside in its accrued claims reserve alone, an amount in excess of 5 months' premiums. As a result, the plan cannot be paid from its contingency reserve unless it has a deficit in the special reserve sufficient to bring the combined reserves below the 5 months' premiums. Despite the fact that this plan has had operating losses during the last two contract periods, we

cannot, under the present regulation, pay over to the plan funds otherwise available in the contingency reserve that are intended to be used to defray premium increases.

The proposed amendment is a solution to this dilema. It preserves the concept of 2 months' premium as a prudent objective of the special reserve but recognizes the need for the plan to set aside more than 3 months' premium as a reserve for accrued claims.

Subparagraph (c)(4) -- The proposed amendment permits those group-practice plans who wish to do so to be experience-rated, rather than community-rated.